STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155761	A. BUILDING 00 B. WING	06/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBURG MEADOWS	2 EAST TILDEN BROWNSBURG, IN46112

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F0000	This visit was for the Investigation of Complaint IN00090550. Complaint IN00090550 substantiated, federal/state deficiencies related to the allegations are cited at F-441. Survey dates: June 01 & 02, 2011 Facility number: 011367 Provider number: 155761 AIM number: 200851590 Survey team: Debra Skinner RN Census bed type: SNF: 25 SNF/NF: 107 Residential: 10 Total: 142 Census payor type: Medicare: 34 Medicaid: 80 Other: 28 Total: 142 This deficiency also reflects state findings cited in accordance with 410 IAC 16.2. Quality review completed 6/6/11 Cathy Emswiller RN	F0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation a requests a Desk Review in lieu of a Post Survey Review on or after June 28, 2011	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F0441 SS=E	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record review, the facility failed to maintain proper disinfection protocol regarding a glucometer usage during the	F0441	F 441It is the practice of this provider to maintain proper disinfection protocol regarding a glucometer usage during the course of test a resident's blood	06/28/2011

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	course of testing a resident's blood sugar. This deficient practice was observed on 1 of 3 nurses, on 1 of 3 glucometers, and on 1 of 3 residents observed for blood sugar testing (resident #B). This deficient practice had the potential to affect 26 residents on the 400 hall. Findings include: Record review on 06/02/11 at 4:30 p.m., of Resident #B's clinical record indicated: Resident #B had diagnoses which included, but were not limited to, insulin dependent diabetes mellitus, chronic kidney disease, and diabetic gastrophoresis. Physician's orders included, but were not limited to the following: Accucheck three times daily at 6 a.m., 11 a.m., and 5 p.m. Record on MAR (medication administration record). Sliding scale with humalog insulin: inject subcutaneously: 0-150--0 units 151-200--2 units 201-250--4 units 251-300--6 units 301-350--8 units 351-400--10 units Call MD (medical doctor) if < (less than) 60 or > (more than) 401.		sugar. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The surfaces on all med carts were cleaned with a Super-sani-cloth on the day this was identified. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All other residents have the potential to be affected. An inservice for Licensed nurses will be completed by the DNS and/or designee on 6/20/11, 6/21/11, 6/22/11, and ongoing to educate staff about using a barrier under the glucometer per the glucometer instructions and correct use of the germicidal dosposable wipe according to manufacturer's instructions. In the case of the PDI Super sani-cloth, this would include letting it sit for 2 minutes and not wiping it off. If in the future, we should change manufactures of germicidal wipes, we will re-inservice on the new manufacturers instructions. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? An inservice for Licensed nurses will be completed by the DNS and/or designee on 6/20/11, 6/21/11, 6/22/11, and ongoing to educate staff about using a barrier under the glucometer per	

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	During observation on 06/02/11 at 11:20 a.m., nurse #3 was observed to perform a blood sugar check on Resident #B as followed: Nurse #3 washed her hands and donned gloves and took the glucometer from a top drawer in the med cart placing the glucometer on top of the med (medication) cart. The glucometer was then sanitized with a disinfectant wipe ("Sani-cloth" germicide disposable wipe) with the glucometer then having been placed back on top of the med cart outside the resident's room with no barrier having been placed between the top of the med cart and the bottom of the glucometer. Nurse #3 then took a dry tissue paper and proceeded to wipe the glucometer dry and placed back on top of the med cart (with no barrier under the glucometer). Nurse #3 had then entered the resident's room, and explained the procedure to the resident, and had placed the glucometer on top of a bedside table without having placed a barrier under the glucometer. Hands were washed and gloves were donned by the nurse. Nurse #3 had then wiped the last digit of the resident's left index finger with an alcohol swab allowing it to dry, and had pierced the resident's finger with a single use lancet. After application of a blood sample to the		the glucometer instructions and correct use of the germicidal dosposable wipe according to manufacturer's instructions. In the case of the PDI Super sani-cloth, this would include letting it sit for 2 minutes and not wiping it off. If in the future, we should change manufactures of germicidal wipes, we will re-inservice on the new manufacturers instructions. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** A CQI tool for Glucometer use has been initiated and will be completed by the Director of Nursing/Designee. This tool will be completed 3 times a week x 2 weeks, weekly x 4 weeks, and then monthly x 3 months. When compliance has reached 100% for 90 days then no further monitoring will be required. If at any time quality issues are observed, then further monitoring will be re-initiated. This CQI tool will be reviewed through the Quality Assurance team monthly.	

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	test strip inserted into the glucometer, Nurse #3 had read the glucometer (213) and had removed the blood-contaminated strip from the glucometer which was still resting on the bedside table, and had put the used strip and the used lancet into the sharps container (on the med cart) located just outside the resident's room near the door. Gloves were removed and hands were washed appropriately. Nurse #3 had then taken the potentially contaminated glucometer from the bedside table and had placed the machine on top of the med cart (again with no barrier under the glucometer to separate the potentially contaminated article from the top of the med cart) and had proceeded to disinfect the glucometer after having used it on Resident #B. Nurse #3 had then placed the glucometer into one of the top med cart drawers. A policy entitled "Procedure for calibrating and cleaning glucose meter" dated 01/2010 indicated: "Purpose: To prevent cross-contamination during resident use...Frequency: The Blood Glucose Meter is to be disinfected prior to the meter being used, between each resident and before returning to the secured cart...Procedure: Wash hands. Assemble equipment...Place paper towel and/or			

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	disposable water proof pad on hard surface. Don clean gloves. Dispense approved germicidal pre-moistened wipe. Wipe entire surface of the blood glucose meter with pre-moistened wipe. If wipe is too saturated, then squeeze or wring out excess liquid...Ensure meter is completely dry. Dispose of used towelette(s)..." Manufacturer's recommendations (no date found) for the use of the "Sani-cloth" germicidal disposable wipe indicated: "Super Sani-Cloth-The 2 minute germicidal wipe/bactericidal-tuberculocidal-virucidal . Suitable for use on equipment requiring alcohol based products...Super Sani-Cloth is a premoistened, durable wipe containing a quaternary/alcohol based solution. Recommended for use in hospitals and other critical care areas where the control of the hazards of cross-contamination between treated surfaces is required...Some organisms are removed from the surface by thoroughly wiping the surface with the wipe. Most remaining organisms are killed within two (2) minutes by exposure to the liquid in the wipe...May be used on hard non-porous surfaces: ...cabinets...patient monitoring equipment...To disinfect...: Use a wipe to remove heavy soil. Unfold a clean wipe and thoroughly wet surface.			

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	Treated surface must remain wet for a full two (2) minutes..." During interview on 06/02/11 at 6:35 p.m., the Administrator voiced the statement she did not understand why the seemingly disinfected glucometer having been placed on the top of the med cart would pose such a cross-contamination risk to residents any more than that of an ink pen or a blood pressure cuff having been placed on the top of the med cart. Based on observation on 06/02/11 at 11:30 a.m., 26 residents were indicated as having received medications from the medication cart which nurse #3 had used to give Resident # B insulin after having taken the resident's blood sugar with the glucometer. This federal tag relates to Complaint IN00090550. 3.1-18(a)			